



VineLine

Paratransit Services

(Rider to Complete)

City of Lodi Transit
221 West Pine Street
Lodi, CA 95240
(209) 333-6706

ADA PARATRANSIT RIDER CERTIFICATION APPLICATION

The information obtained in this certification process will be used only by the transit agencies in San Joaquin County for the provision of transportation services and will not be provided to any other person or agency without prior written approval of the applicant.

☐ **New Application** or ☐ **Recertification**

Please check the transit agency you are applying for (you may select more than one):

- ☐ Lodi VineLine ☐ Tracer Transit ☐ Manteca Transit ☐ City of Escalon
☐ For service within City of Stockton and/or unincorporated areas of San Joaquin County, your application will be forwarded to San Joaquin Regional Transit District.

APPLICANT INFORMATION (Please print or type)

Name _____ / _____ / _____
Last First Middle Initial

Address _____ Apt # _____ Cross St. _____

Mailing Address, if different than above

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Date of Birth ____/____/____

Male ☐ Female ☐

Last four digits of your Social Security Number _____

Please provide the name and phone number of a LOCAL friend or relative to contact in the event of an emergency:

Name_____ Relationship_____

Daytime Phone _____ Evening Phone_____

1. Do you use any of the following aids for mobility? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Electric Wheelchair |
| <input type="checkbox"/> Power Scooter | <input type="checkbox"/> Cane |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Oxygen Tank | <input type="checkbox"/> Service Animal |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> None |

2. Is your mobility device oversized? ☐ Yes ☐ No

a. If yes, please explain: _____

b. Does your mobility device weigh less than 800 pounds when occupied?

☐ Yes ☐ No

3. Is your condition temporary? ☐ Yes ☐ No

If yes, expected duration: ____/____/____

4. Does your condition change from time to time due to medications, medical treatments, other?

☐ Yes ☐ No

If yes, please explain

Type of disability:

5. I have a ☐ **Visual** ☐ **Physical** ☐ **Mental** Impairment

6. **What** is your disability and **how** does it make it **impossible** for you to use the fixed route service? _____

7. How far can you continuously walk **OR** advance your manual wheelchair without the help of another person? (i.e., number of blocks) _____

Could you travel further if you stopped to rest?

☐ Yes ☐ No ☐ Sometimes

(If No or Sometimes, please explain why)

8. Have you ever used any of these transit services? Check all that apply:

☐ Fixed Route ☐ Paratransit/Dial-A-Ride ☐ RTD Hopper ☐ Other_____

9. How many blocks from your residence is the nearest accessible bus stop?

☐ Less than 1 Block ☐ 2 to 4 Blocks ☐ 4 or more ☐ Don't know

10. Can you independently get on and off a lift-equipped bus?

☐ Yes ☐ No ☐ Sometimes ☐ Don't know

(If No or Sometimes, please explain why)

11. Would your ability to use public transit be affected by weather or environmental/architectural barriers that block your path of travel? (e.g. temperature extremes, no sidewalks, lack of signal lights at a busy intersection, etc.)

☐ Yes ☐ No (If Yes, please explain why)

12. Can you ask for, understand, and follow directions?

☐ Yes ☐ No ☐ Sometimes

(If No or Sometimes, please explain why)

13. Can you cross a busy intersection?

☐ Yes ☐ No ☐ Sometimes

(If No or Sometimes, please explain why)

14. If you are approved for Paratransit Services will you require a personal care attendant?

☐ Yes ☐ No

Certification of Applicant

I hereby certify that, to the best of my knowledge, the information I have given in this application is correct and the application will be returned if it is not complete.

I understand that the results of the review will be based on my ability to use the fixed route system. Verification of my disability by my physician or health care professional, identified below, does not guarantee my eligibility for ADA certification of paratransit service.

Signature of Applicant _____

Date _____

If someone other than the applicant completed this application, the following information must be provided.

Name of person completing the application _____

Relation to the applicant _____

Daytime phone # _____

PLEASE MAIL COMPLETED FORM TO:

City of Lodi Transit

Attention: ADA Coordinator

221 West Pine Street

Lodi, CA 95240

IF YOU HAVE QUESTIONS, PLEASE CALL 333-6706